BUCHLER
ORTHODONTICS
AMYBUCHLERDMD

Adult Patient Information

Please complete both front and back sides.

Date: _____

Patient's Name _____ Birthdate_____
Nickname _____
Address_____
Home Phone _____Cell Phone_____ Email Address_____
Name of Family Members in Orthodontic Treatment: _____
Whom May We Thank For Referring You To Our Office? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient_____
Spouse's Name _____
Residence _____
Home Phone _____ Work Phone_____ Cell Phone_____
Email Address _____
Employer _____ Occupation_____ No. Years Employed _____

PRIMARY INSURED INFORMATION

Name of Insured: _____
Insured's Birthday: _____ SSN: _____
Relationship to Patient: _____
Address of Insured: _____
City: _____ State: _____ Zip: _____
Employed By: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Dental Insurance Co. Name: _____
Ins. Address: _____
City: _____ State: _____ Zip: _____
Ins. Group#: _____ Ins. Phone: _____

SECONDARY INSURED INFORMATION

Name of Insured: _____
Insured's Birthday: _____ SSN: _____
Relationship to Patient: _____
Address of Insured: _____
City: _____ State: _____ Zip: _____
Employed By: _____
Work Address: _____
City: _____ State: _____ Zip: _____
Dental Insurance Co. Name: _____
Ins. Address: _____
City: _____ State: _____ Zip: _____
Ins. Group#: _____ Ins. Phone: _____

EMERGENCY INFORMATION

Name Of Nearest Relative Not Living With You _____
Complete Address_____
Phone _____

FOR OFFICE USE ONLY

DIAG RECORDS: $ _____

TREATMENT FEE: $ _____
INSURANCE: $ _____
PERSONAL: $ _____

DOWN PMT: $ _____

MONTHLY PMTS: $ _____

Consult: Dr B C
Refer to: Endo GP OS Perio
Midlines: Upper R L _____ mm
Lower R L _____ mm
TMJ_____
Type: Mini Clear Self-Lig

Treatment: Full
Phase 1 2
Limited
Surgical
Invisalign
Appliances:
Extractions: _____

MEDICAL HISTORY

Physician _____

Please circle Yes or No (If Yes, please fill in details)

❑ Yes ❑ No Are you taking any medication? _____
❑ Yes ❑ No Do you have any allergies to medicines, latex or metals? _____
❑ Yes ❑ No Have you ever been involved in a serious accident? _____
❑ Yes ❑ No Do you smoke? If Yes, how much? _____

Female Patients Only:

❑ Yes ❑ No Are you pregnant now? _____

Circle Any Of The Medical Conditions Below That You Have Had Or Currently Have.

Abnormal Bleeding/	Fainting Spells	High/Low Blood Pressure	Psychiatric/Learning Problems
Anemia	Gastrointestinal Disorders	HIV / Aids	Radiation/Chemotherapy
Arthritis	Heart Problems/Murmur	Kidney Problems	Sinus/Breathing Problems
Asthma or Hayfever	Hemophilia	Osteoporosis	Tonsils Removed
Diabetes	Hepatitis/Liver Problems	Pneumonia	Tumor or Cancer
Epilepsy	Herpes	Prolonged Bleeding	

Are There Any Medical Conditions We Have Not Discussed That You Feel We Should Be Aware Of? _____

_____

_____

DENTAL HISTORY

General Dentist _____ Date Of Last Visit _____

What Concerns You Most About Your Teeth? _____

❑ Yes ❑ No Do you have any type of thumb or tongue habit? _____
❑ Yes ❑ No Are you a mouth breather? _____
❑ Yes ❑ No Are you aware that some appointments will be during work hours? _____
❑ Yes ❑ No Have you ever been evaluated for ortho treatment? If yes, with who and when? _____
❑ Yes ❑ No Have you ever had problems with any previous dental work? _____
❑ Yes ❑ No Do you now or have you ever experienced pain, clicking or popping noises in your jaw joint? _____
❑ Yes ❑ No Has your jaw joint ever locked or felt like it was sticking? _____
❑ Yes ❑ No Have you ever had an injury to your mouth, teeth or chin? _____
❑ Yes ❑ No Do you grind or clench your teeth? _____

AUTHORIZATIONS

I authorize this office to affix my name to any and all claims or documents related to any and all dental benefits due me and my dependents through my employment. I authorize payment of dental benefits otherwise payable to me, directly to this office. I understand that where appropriate, credit bureau reports may be obtained. I certify that I have read and understand the foregoing questions. To the best of my knowledge, the foregoing questions have been completely and accurately answered. I will notify the doctor of any change in my health history. In addition I authorize Dr. Amy Buchler to perform a complete orthodontic evaluation.

Patient Signature: _____ Date:_____

Dr. Signature: _____ Date: _____

Updates (Date & Initial) _____

_____

_____